Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

MEDICAID MEMO

MEMO	Special
DATE	9-13-96

TO: Health Maintenance Organizations Providing Services to Virginia Medicaid Recipients

FROM: Joseph M. Teefey, Director
Department of Medical Assistance Services

SUBJECT: Contents of Notices to Medicaid Recipients

This memo is to inform Health Maintenance Organizations (HMOs) of the contents of notices to be sent to Medicaid recipients when services are denied or reduced. Also noted is when coverage for services must be continued when an appeal is filed. However, when services must be continued if an appeal is filed is subject to change due to continuing policy analysis. Also, the determination of applicable notice requirements when assignment to the HMO is discontinued during a period of authorization of a particular medical procedure is still being explored. When changes are made in these areas, you will be informed via a Medicaid Memo from the Department of Medical Assistance Services (DMAS). The determination of continued coverage will be made by the Appeals Division at DMAS, and you will be informed by telephone.

The notice to the Medicaid recipient must:

- Tell what was denied or reduced;
- Give the reason for the denial or reduction in coverage;
- Tell about the opportunity to file a grievance with the HMO (including the telephone number and the contact person at the HMO);
- Give information about requesting an appeal with the name and address of the Appeals Division at DMAS and including that the appeal must be in writing; and
- Give information in (at least) ten point type.

In all cases listed below, the recipient may be sent a copy of the notice that is sent to the primary care physician (PCP), if the PCP notice contains all of the necessary notice information. If the notice does not contain all of the

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necessary information, a separate notice with all of the necessary information must be sent to the recipient. Please note: the recipient, not the PCP, is the one who appeals to DMAS the denial or reduction in services.

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Situation	**Recipient Notice Required?**	**Continued coverage if an appeal is filed?**
Verbal or written request from a recipient for a Medicaid covered service is denied.	YES	NO
PCP requests, verbally or in writing, coverage of a ***Medicaid*** covered service, and denial is sent to the PCP.	YES	NO (Unless this is a termination or reduction of a service during a period of authorization.)
A ***Medicaid*** covered service is authorized for a number of days, visits, etc., and a request is made for additional days. *Note: This does not include a decision made jointly by the provider or PCP and the Utilization Management/Prior Authorization (UM/PA) staff on initial discussions to determine medically necessary services unless not agreed to by the provider or PCP.*	YES	NO
A ***Medicaid*** covered service is discontinued during a period of authorization.	YES	YES
Any time a level of care lower than the one requested is authorized (reduction in service). *Note: This does not include a decision made jointly by the provider or PCP and the UM/PA staff on initial discussions to determine medically necessary services unless not agreed to by the provider or PCP.*	YES	Depends on the specific situation.
Denial of a non-***Medicaid*** covered service.	NO	NO

Medicaid covered services are as defined in the State Plan for Medical Assistance.

If you have questions, please call Diana Thorpe, Director, Appeals Division, at 804-371-8488.